Theresa M. Rubadue-Doi DC 628 NW York Dr., Suite 104 Bend, Oregon 97701 541-388-2429 fax 541-388-2439

Patient's Name:________________________
Date of Birth:__________________________
Today's Date:__________________________

Current Condition

- Describe your current symptoms?

____
____
____

- How often do you experience your symptoms?

Constant (76-100% of the day) Frequent (51-75%) Occasional (26-50%) Intermittent (0-25%)

- What is the nature of your symptoms?

Sharp Dull Ache Numb Shooting Burning Tingling Tight

- How are your symptoms changing?

Getting Better Getting Worse Not Changing

- Has it affected your sleep? Yes No
- What increases the pain?

____

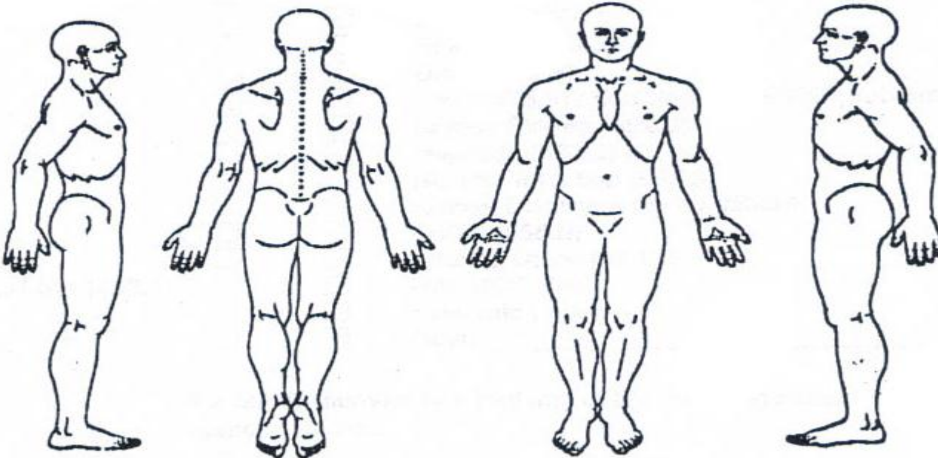
- What decreases the pain?____

____

Indicate your average intensity of pain/symptoms:

0 (None) 1 2 3 4 5 6 7 8 9 10 (severe)

Have you had spinal x-rays, MRI, CT Scan, Bone Scan ? *no *yes Date Taken:



Indicate where you have pain or other symptoms on these diagrams